DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF AGING AND ADULT SERVICES
ADULT DAY HEALTH SERVICES
PROGRAM CERTIFICATION REPORT
FACE SHEET

( ) Certification
( ) Certification Renewal
( ) Denial or Revocation
( ) Change in Program Director/ Operator

ACTION REQUESTED

( ) Change of Capacity
( ) Change of Address
( ) Provisional

Type of Program ( ) Public ( ) Profit ( ) Non-Profit ( ) Adult Day Health Center ( ) Adult Day Health Home ( ) Combination Program Program Offers Specialized Care for ( ) Dementia ( ) HIV/AIDS ( ) Developmental Disabilities ( ) NONE	Date of Report: _____ Certification Period: To
Name of Program:	Capacity:
Address (Street, City, Zip Code):	County:
Mailing Address (if Different from Above):	Program Telephone (Area Code and No.):
Name of Director/Operator:	

Please check the appropriate blocks to indicate which materials are attached. All of the materials listed should be attached for initial certification. Materials which should be included for certification renewal or change of address, program director, or capacity are so indicated.

( ) Program Policy Statement (certification renewal, *if changed* during the certification period)

( ) Organizational Diagram for Centers (certification renewal, *if changed* during the certification period)

( ) Job Descriptions (certification renewal, *if changed* during the certification period)

( ) Personnel Policies (certification renewal, *if changed* during the certification period)

( ) Annual Budget (certification renewal)

( ) Floor Plan (change of address, change of capacity, or certification renewal *when structural building modifications have been made*)

( ) Fire Inspection Report, DSS-1498 or the equivalent (certification renewal and change of address)

( ) Building Inspection Report, DSS-1499 or the equivalent (certification renewal or change in capacity *when structural building modifications have been made or change of address)*

( ) Sanitation Evaluation Report, DSS-2386 or the equivalent (certification renewal and change of address)

( ) Articles of Incorporation, Bylaws, names and addresses of board members, if applicable (certification renewal, *if changed* during the certification period)

( ) Current Medical Report on each paid staff (certification renewal or change in program director/ operator)

( ) Current CPR and First Aid for Staff <u>and Substitutes</u> (certification renewal)

( ) Department of Health Standards Review, DSS-6205, Part B (certification renewal or change of address)

Other Attachments, Please Specify

( ) _____
( ) _____

SEE REVERSE SIDE FOR INSTRUCTIONS

DAAS-6205 (8/04)
Program Operations
Prepare Four Copies: Original to Adult Day Care/Day Health Consultant, one copy to Division of Aging and Adult Services, one copy to day health program, one copy to county department of social services and one copy kept at local health department.

ADULT DAY CARE/DAY HEALTH CERTIFICATION REPORT

Instructions for Completion

The Adult Day Care/Day Health Certification Report is completed by the county department of social services and local health department to document whether or not standards are met by the adult day care/day health program. It is submitted with other necessary information to the Adult Day Care/Day Health Consultant, Division of Aging and Adult Services.

The form is in two parts. The first part, the Face Sheet, contains identifying and general information regarding the adult day care/day health program, the certification action requested and a checklist for necessary information to accompany the form. The Face Sheet must be submitted for all actions regarding certification which are listed on the top of the form. Reference should be made to Section VI of the certification standards manual for information regarding procedures and requirements for all actions concerning certification. **Any change of address (location) of an existing program is to be treated as an initial certification.** Change of capacity requires submission of a floor plan which identifies sufficient square footage, toilets and furnishings to support the requested capacity. A building inspection report is required if structural modifications have been made to support the increased capacity. A medical report for any new staff members employed to support the capacity increase must also be submitted.

The second part, the Standards Review, is an outline and checklist of the certification standards which must be met by the adult day care/day health program. The Standards Review Section is to be submitted with the Face Sheet for initial certification (including change of address), denial, revocation, and renewal of certification. The Standards Review is divided into two parts. Part A is to be completed by the county department of social services and Part B by the local health department.

The outline format of the Standards Review follows the sequence of the certification standards manual. Those items in the certification standards manual that apply only to adult day care are not included in this standards review section. Some parts of the review outline will not be applicable to the adult day care/day health program being reviewed, depending on whether the program is a center or a home. Those parts are clearly identified on the form. There is a space at the end of each part of the outline which is to be used to comment regarding non-compliance with any standard in that part. The concluding summary should relate to those comments in describing the program's overall performance and recommending action regarding certification. It should be understood that for initial certification of a new program, some areas will be incomplete (for example, participant and program records). In such instances, plans and capability to comply with standards should be reviewed.

After completing the Standards Review, the county department of social services in collaboration with the local health department should indicate whether or not certification is recommended. If the agencies do not recommend certification, the appropriate block "Provisional", "Denial", or "Revocation" should be checked and statement of reasons attached.

STANDARDS REVIEW

I. ADMINISTRATION

A. Governing Body

YES NO

1. Adult Day Health Center Governing Body: _____
   Auspices Under Which Center Operates
2. Governing Body or Operator Carries Out Responsibilities As Specified. Responsibilities Include:

( ) ( ) a. Approval of Organizational Structure (Centers only)
( ) ( ) b. Adoption or Development of Annual Budget
( ) ( ) c. Regular Review of Financial Status, Including Annual Budget, Monthly Accounts of Income and Expenditures to Reflect Against Budget, and Annual Audit for Centers; or Maintenance of Monthly Accounts of Income and Expenditures for Homes
( ) ( ) d. Appointment of Program Director for Centers
( ) ( ) e. Establishment of Written Policies Regarding Operation in Direct and Understandable Language

B. Program Policy Statement

( ) ( ) 1. Program Goals Consistent with Definition of Adult Day Health Services
( ) ( ) 2. Enrollment Criteria and Procedures are Flexible, Specific, and Provide for Dismissal of Participants Who Can No Longer Be Served.
( ) ( ) 3. Hours and Days of Operation
( ) ( ) a. Hours and Days of Operation Set to Meet the Needs of Participants and Families.
( ) ( ) b. Care and Services Provided Throughout All Hours Participants are Present.
( ) ( ) c. Program is in Operation a Minimum of 6 Hours Each Day.
( ) ( ) d. Care and Services Provided at Least 5 Days Per Week, with Exceptions Noted.
( ) ( ) e. Attendance Schedules For Participants Designed to Accommodate Caretaker's Work Schedule.
( ) ( ) 4. Types of Services Provided, Including Transportation.
( ) ( ) 5. Medications.
( ) ( ) 6. Additional Enrollment and Participation Requirements are Met.
( ) ( ) a. Each Adult Day Health Participant Requires Monitoring of A Medical Condition; Assistance with Supervision of ADL's; or Administration of Medication, Special Feedings or Other Health Care Services.
( ) ( ) b. Persons Whose Needs Exceed The Capabilities of the Program Are Not Enrolled, as Specified in Standards.
( ) ( ) c. Each Adult Day Health Participant's Service Plan Includes Health Needs and Goals To Meet Health Needs.
( ) ( ) d. Combination Programs Serve at Least 25% Adult Day Care Participants, as Specified in Standards.

C. Personnel Policies

( ) ( ) Personnel Policies Developed and Shared with Employees, Include Necessary Information and Comply with Wage and Hour Regulations.

D. Insurance

( ) ( ) Adequate Liability Insurance for Facility and Vehicles.

If NO is checked for any standard under ADMINISTRATION, Please explain and comment as to actions needed and plans for the program to comply.

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II. PERSONNEL

List Names and Positions of Paid Staff Members

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_____

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YES NO

A. General Personnel Requirements

( ) ( ) 1. Staff Positions Planned and Filled According to Program Goals and Manpower Needs with Staff Qualified for Position Held.
( ) ( ) 2. Staff are Competent, Ethical and Qualified for the position held.
( ) ( ) 3. Written Job Description for Each Position Containing Required Information.
( ) ( ) 4. References Required in Recruitment of Staff.
( ) ( ) 5. Established Review Process for Each Employee.
( ) ( ) 6. Provision for Orientation and Staff Development of New Employees and Volunteers, and Ongoing Development and Training of All Staff.
( ) ( ) 7. Minimum of one Substitute Staff Person With Same Qualifications, Training, and Personal Credentials as Regular Staff is available in the absence of regular staff.
( ) ( ) 8. Medical Report Presented Prior to Beginning Employment and Annually Thereafter.

B. Staffing Patterns

( ) ( ) 1. Staffing Adequate to Meet Program Goals and Objectives.
( ) ( ) 2. Substitutes Used to Maintain Ratio When Regular Staff Absent. (Explain)

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C. Program Director

( ) ( ) 1. Program Has Full-Time Director or Director/Health Care Coordinator, as Specified in Standards.
( ) ( ) 2. Program Director Has Authority and Responsibility for Program Management.
3. Program Director Meets Minimum Qualifications (When Position is Combined as Director/Health Care Coordinator Qualifications Outlined in Standards For Health Care Coordinator Must Also Be Met):
( ) ( ) a. At Least 18 Years of Age;

YES NO

( ) ( ) b. At Least 2 Years of Formal Post Secondary Education or High School Education and a Minimum of Two Years of Experience and Training in Services To Elderly or Handicapped Adults;

( ) ( ) c. At Least One Year of Human Services Work Experience and Demonstrated Ability in Supervision and Administration;

( ) ( ) d. Medical Report Presented Prior to Employment and Annually Thereafter;

( ) ( ) e. At Least 3 Current Reference Letters or the Names of Individuals With Whom a Reference Interview Can Be Conducted.

( ) ( ) 4. Governing Body Considered Characteristics Specified in Standards in Employing Director.

D. Applies Only to Adult Day Care Homes.

E-G Reviewed in Part B of This Report

( ) ( ) **H. Does the Program Use VOLUNTEERS? IF YES:**

( ) ( ) 1. Volunteers Have Written Description of Duties and Responsibilities;

( ) ( ) 2. Volunteers Are Provided Orientation and Training to the Program;

( ) ( ) 3. Paid Staff Are Provided Required Information Regarding Volunteers and Are Involved in Writing Volunteer Duties;

( ) ( ) 4. Provision Is Made for Evaluation of Volunteer's Job Performance; and

( ) ( ) 5. Recognition and Appreciation of Volunteers.

If NO is Checked for Any Standard Under PERSONNEL Please Explain and Comment As to Actions Needed and Plans for the Program to Comply.

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III. FACILITY

A. General Requirements

( ) ( ) 1. Facility and Grounds Clean and Safe for Aging, Disabled and Handicapped Adults.

( ) ( ) 2. Facility Complies with All Applicable Zoning Laws.

( ) ( ) 3. Environment Within Facility is Pleasant and Comfortable.

( ) ( ) 4. Facility Provides Flexible and Adaptable Spaces for Appropriate Activities, Which Provide Opportunities for Group Activities and Privacy.

a. Applies To Adult Day Care Only.

( ) ( ) b. Kitchen is Adequate, if Meals Prepared on Premises. If N/A, Check ( )

( ) ( ) c. Storage Areas Adequate in Size and Number for Storage of Items Specified in Standards.

( ) ( ) d. Minimum of 1 toilet for each 12 Adults and 1 Hand Lavatory for Each 2 Toilets.

( ) ( ) 5. Rugs and Floor Coverings Securely Fastened, Floors Not Slippery.

( ) ( ) 6. Telephone Available as Required.

B. Additional Facility Requirements for Adult Day Health

( ) ( ) 1. Facility Space Provides Sufficient Dimension and Size to Allow for Required Group Activities.

YES NO

( ) ( ) a. **Day Health** Centers and Homes Provide at Least 60 Square Feet of Indoor Space Excluding Hallways, Offices and Restrooms for Each Participant. If N/A, check ( )

( ) ( ) b. **Combination** Programs Provide at Least 50 Square Feet of Indoor Space Excluding Hallways, Offices and Restrooms for Each Participant. If N/A, check ( )

( ) ( ) c. Day Health Programs or Combination Programs In A **Multi-Use Facility** Must Have a Nucleus Area Separate from Other Activities in the Rest of the Building. If N/A, check ( )

( ) ( ) (1) Nucleus Area Provides at Least 40 Square Feet of Indoor Space As Specified in Standards, and a Minimum of 20 Square Feet Per Participant Must Be Provided in Other Space in the Facility Designated for Use by the Day Health Program.

( ) ( ) (2) Participation is Open Only to Persons Enrolled in the Program and to Visitors on a Planned Basis.

( ) ( ) 2. Facilities with a Capacity of More than 12 Adults, Including Staff, Have Separate Restrooms for Males and Females. Each Restroom Contains a Minimum of 1 Toilet and 1 Lavatory. If N/A, check ( )

3. **Reviewed in Part B of This Report.**

( ) ( ) 4. Facility Has Sufficient Private Offices for Staff Use, Including Use for Conferences with Individual Participants and Their Families. A Minimum of 1 Private Office with Sufficient Equipment and Furnishings for Administrative Purposes and for Conferences. Programs in Multi-Use Facilities Must Have Their Own Offices Readily Accessible to Family Members, Staff and Participants.

5. **Medical Supplies and Equipment Reviewed in Part-B of This Report.**

C. Day Health Programs In Multi-Use Facilities If N/A, check ( )

( ) ( ) 1. Program is Self-Contained with Its Own Staff and Separate Area.

( ) ( ) 2. Participation is Open Only to Persons Enrolled in the Program and to Visitors on a Planned Basis.

( ) ( ) 3. Written Agreement Regarding the Facility's Cooperative Use.

D. Building Construction

( ) ( ) 1. Building Meets Approval of Local Building Inspector.

( ) ( ) 2. Facility Has Entrance at Ground Level With No Steps or Ramp Which Meets Stated Specifications.

( ) ( ) 3. All Toilets Used by Participants Have Grab Bars or Safety Frames.

( ) ( ) 4. If Adult Day Health Home, Requirements for Adult Day Health Homes as Specified in Appendix A of Standards are Met. If N/A, check ( )

E. Equipment and Furnishings

( ) ( ) 1. Equipment and Furnishings Adequate to Meet The Needs of Participants and Staff..

( ) ( ) a. Facility Has at Least 1 Straight Back or Sturdy Folding Chair for Each Participant and Each Staff Member.

( ) ( ) b. Table Space Adequate for All Participants to be Served a Meal at a Table at the Same Time, and for Program Activities.

YES NO

( ) ( ) c. Lounge, Sofa, or Recliner Seating as Specified.
( ) ( ) d. Quiet and Separate Space with Beds or Cots.
( ) ( ) 2. All Equipment and Furnishings in Good Condition and Safe for Use.

If NO is Checked for Any Standard Under FACILITY, Please Explain and Comment as to Actions Needed and Program Plans to Insure Compliance:

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IV. PROGRAM OPERATION

A. Planning Program Activities

1. Enrollment Policies and Procedures

( ) ( ) a. Enrollment Determined on the Basis of Enrollment Policies
( ) ( ) b. Procedures Include A Personal Interview with at Least One Staff Member.
( ) ( ) c. Signed Application and Current Medical Report Obtained for Each Individual Prior to Attendance as Participant.
( ) ( ) d. Program Policies Discussed with Each Applicant and a Copy of the Policy Statement is Given to Each Applicant and to Family or Caretakers.

2. Planning Services for Individual Participants

( ) ( ) a. Individual Service Plans Developed, Including Necessary Information and Involving Appropriate Persons, Initiated at Enrollment and Reviewed at Regular Intervals.
( ) ( ) b. Changes in Behavior, Attitude, and Problems and Needs for Help Are Reported to Appropriate Person.
( ) ( ) c. Participants or Responsible Party Involved in Selecting Days to Attend.
( ) ( ) d. Participant Absences Checked Out at Least by Phone on Date of Occurrence.
( ) ( ) e. Participants Sign Out When Leaving Program During Day, or Whoever is Responsible for Participant is Contacted Before Participant Leaves Facility. Contact is Documented in Participant's Record.

3. Program Plan

a. Program Plan Meets the Following Criteria:

( ) ( ) (1) Based on Elements of Individual Service Plans.
( ) ( ) (2) Primary Program Mode is Group Process, Provision Made for Individual Activities and Services.
( ) ( ) (3) Activities are Consistent with Program Goals.
( ) ( ) (4) Activities are Planned Jointly by Staff and Participants.
( ) ( ) (5) All Activities are Supervised by Staff.
( ) ( ) (6) Participants Have Choice of Refusing to Participate in Any Given Activity.

b. Program Plan Provides for the Following Activities to be Available on Daily Basis:

( ) ( ) (1) Diversional.
( ) ( ) (2) Educational.

YES NO

( ) ( ) (3) Social.
( ) ( ) (4) Volunteer Service.
( ) ( ) (5) Program Assistance.

c. Program Plan Provides Balance of Activities Designed to:

( ) ( ) (1) Improve the Capacity for Self-Care and Personal Hygiene, Increased Self-Worth and Dignity.
( ) ( ) (2) Improve Social and Interactional Skills.
( ) ( ) (3) Provide Opportunities for Social and Community Activities to Promote Creative Use of Leisure Time.
( ) ( ) (4) Improve Capacity for Independence.

( ) ( ) d. Program Plan in Writing and Specifies:
( ) ( ) (1) Name, Days of Week, and Approximate Length of Time of Each Activity.
( ) ( ) (2) Length of Time the Plan is to be Followed.

( ) ( ) e. Schedule of Activities is Posted Weekly or Monthly, Listing Planned Activities by Date.
( ) ( ) f. Physical Activity is Encouraged.
( ) ( ) g. Outings are Scheduled as Often as Possible.
( ) ( ) h. Staff are Encouraged to Explore and Use Community Resources.
( ) ( ) i. Community Services and Resources Used to Extent Possible by Participants as Part of Program.

B. Health and Personal Care Services Reviewed in Part B of This Report.

C. Nutrition

( ) ( ) 1. Nutritious Mid-Day Meal Provided to Each Participant as Required.
( ) ( ) 2. Meals Prepared and Served in Sanitary Manner.
( ) ( ) 3. Nutritious Mid-Morning and Mid-Afternoon Snack Offered Daily to Each Participant. Snacks Planned as Specified in Standards.
( ) ( ) 4. Therapeutic Diet Provided if Prescribed for Any Participant. If Diets Prepared by Program Staff, Such Staff Have Necessary Training. If N/A, check ( )
( ) ( ) 5. Registered Dietitian or Certified Nutritionist Gives Consultation to Staff on Basic and Special Nutritional Needs.

D. Transportation *If N/A, check ( )*

( ) ( ) 1. Transportation Provided in Keeping with Needs of Participants.
( ) ( ) a. Each Person Transported Has Seat in Vehicle.
( ) ( ) b. Participants Offered Opportunity for Rest Stop At Least Every 30 Minutes.
( ) ( ) c. Vehicles Used for Transportation Equipped With Seatbelts.
( ) ( ) 2. Participants Use Public Transportation, If Available. Relatives and Other Responsible Parties are Encouraged to Provide Transportation.

E. Emergencies and First Aid

1. Plan for Emergencies:

( ) ( ) a. In Writing and Prominently Displayed in Facility.
( ) ( ) b. Plan Relates to Medical and Non-Medical Emergencies and Specifies Responsibilities of Each Staff Person.
( ) ( ) c. All Staff Knowledgeable about Plan.
( ) ( ) d. Regular Emergency Drills are Conducted and Documented as to Date and Kind of Emergency.
( ) ( ) 2. Evacuation Plan Posted in Each Room and Fire Drills Conducted at Least Monthly (for programs without a sprinkler system) or Quarterly (for programs with a sprinkler system).

YES NO

( ) ( ) 3. All Physically Able Staff Have Training in Standard First Aid and Cardio-Pulmonary Resuscitation. Training is Current as Determined by the Organization Conducting the Training and Issuing the Certification.
( ) ( ) 4. Arrangements Made for Emergency Medical Assistance.
( ) ( ) 5. Sickness and All Accidents Reported to Program Director Who Takes Required Action.

F. Reviewed in Part B of This Report

G. Program Evaluation

( ) ( ) 1. Plan for Evaluation of Operation and Services in Writing and Includes Required Information.
( ) ( ) 2. Formal Evaluation Conducted at Regular Intervals, at Least Annually.
( ) ( ) 3. Specified Parties Involved, as Appropriate, In Evaluation Process.
( ) ( ) 4. Evaluation Focuses on Required Areas.
( ) ( ) 5. Written Report of Evaluation on File.

If NO is Checked for Any Standard Under PROGRAM OPERATION, Please Explain and Comment as to Actions Needed and Program Plans to Insure Compliance:

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V. RECORDS

A. Individual Participant Records

( ) ( ) 1. Individual Folder is Established and Maintained for Each Participant, Including:
( ) ( ) a. Signed Application, Including:
( ) ( ) (1) Client's Full Name.
( ) ( ) (2) Address and Telephone Number.
( ) ( ) (3) Date of Birth, Marital Status, and Living Arrangement.
( ) ( ) (4) Time of Day Client Will Arrive and Leave.
( ) ( ) (5) Travel Arrangements for Client.
( ) ( ) (6) Name, Address, and Phone Number of at Least 2 Family Members or Friends.
( ) ( ) (7) Name, Address, and Phone Number of the Individual's Licensed Medical Service Provider.
( ) ( ) b. Copies of All Current and Former Signed Authorizations to Receive and Give Out Confidential Information, Obtained Each Time Request for Information Is Made From a Different Party.
( ) ( ) c. Signed Authorization for Emergency Medical Care.
( ) ( ) d. Signed Medical Report Completed Prior to Enrollment and Annually Thereafter; The Report Includes Information On:
( ) ( ) (1) Current Diseases and Chronic Conditions and Extent to Which Special Attention and Restriction of Activities are Required;
( ) ( ) (2) Presence and Degree of Psychiatric Problems;
( ) ( ) (3) Amount of Direct Supervision Required;
( ) ( ) (4) Any Limitations on Physical Activities;

YES NO

( ) ( ) (5) Listing of All Medications With Dosages and Times to be Administered;
( ) ( ) (6) Most Recent Date Participant Seen by Doctor.
( ) ( ) e. Written Report of Staff Discussions, Conferences, Consultation with Family or Other Parties, Evaluation of Progress, and Other Significant Information.
( ) ( ) f. All Service Plans for The Participants.
( ) ( ) g. Signed Authorization Permitting Photographs or Slides.
( ) ( ) h. Statement Signed by Responsible Person Reflecting Agreement Regarding Policies.

B. Program Records

Program Records Contain:

( ) ( ) 1. Program Plans.
( ) ( ) 2. Monthly Records of Expense and Income.
( ) ( ) 3. All Bills, Receipts, and Other Documentation of Expenses and Income.
( ) ( ) 4. Daily Record of Attendance of Participants by Name.
( ) ( ) 5. Accident Reports.
( ) ( ) 6. Record of Staff Absences, Annual Leave and Sick Leave, with Dates and Names of Substitutes.
( ) ( ) 7. Reports on Emergency and Fire Drills.
( ) ( ) 8. Individual Personnel Records on All Staff, Including Required Information. If operator only staff, check N/A ( )
( ) ( ) 9. Copy of All Written Policies, As Required.
( ) ( ) 10. Program Evaluation Reports.

If NO is Checked for Any Standard Under RECORDS, Please Explain and Comment as to Action Needed and Program Plans to Comply._____

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Part 1 of Special Care Services MUST BE COMPLETED on ALL PROGRAMS !

YES NO

VI. SPECIAL CARE SERVICES (Part 1)

A. Screening For Special Care Services (All Renewal Or New Certifications Must Complete And Submit This Section)

( ) ( ) 1. The Program's Name Includes or Mentions a Disease, Condition or Disability Group.
( ) ( ) 2. In the Program Policy Statement or the Program Brochure, the Program Advertises, Claims or Markets Special Care Services by Name for Any Disease, Condition or Disability Group.
( ) ( ) 3. Program Goals Refer to Specialized Services or Care for Persons with Certain Conditions or Disabilities.
( ) ( ) 4. Enrollment Policies Target or Mention Specialized Care for Persons with Alzheimer's Disease or Other Dementia, Developmental Disabilities, Persons with HIV-AIDS or Other Special Conditions or Disabilities.
( ) ( ) 5. Brochures, Pamphlets, Posters or Other Outreach or Publicity Material Reference Special Care or Special Programming for Persons With:
( ) ( ) Alzheimer's Disease or Other Dementia

YES	NO		
( )	( )		Developmental Disabilities
( )	( )		Parkinson's Disease
( )	( )		HIV-AIDS
( )	( )		Others: Specify_____
( )	( )	6.	Brochures or Pamphlets Refer to Care for Persons with a Special Disability or Condition by Separate Programming.
		7.	**If "Yes" Is Checked In Any Of The Above, Determine That:**
( )	( )	**a.**	The Program Provides Specialized Care for One or More of the Above Groups, **OR**
( )	( )	**b.**	The Program Does Not Provide Specialized Care.

If 7b Above Is Checked, Part 2 <u>Does Not</u> Need To Be Completed.
If 7a Above Is Checked, <u>Complete</u> Part 2 (Specialized Care).

Specialized Care (Part 2)

Program Policies and Implementation for the Special Care Group Includes the Following:

		1.	The Statement of Mission and Objectives For Special Care Addresses:
( )	( )	a.	Environmental Safety and Appropriateness
( )	( )	b.	Type and Frequency of Daily Activities With Regard to Specialized Service
( )	( )	c.	Service Plans that Emphasize Capacities as Well as Deficits
( )	( )	d.	Methods of Behavior Management Which Preserve Dignity Through Design of Physical Environment, Physical and Social Activity, Appropriate Medication Administration, Proper Nutrition and Health Maintenance.
( )	( )	2.	Process and Criteria for Enrollment and Discharge From Special Care.
( )	( )	3.	The Policies Describe Accurately the Special Care Services in the Center.
( )	( )	4.	Participant Assessment and Service Planning Includes Opportunity for Family Involvement in Planning and Implementation of the Service Plan, **AND** Participant Assessment and Service Planning Provides for Appropriate Response to Changes in the Participant's Condition.
( )	( )	5.	Safety Measures Address Specific Dangers Such as Wandering, Ingestion, Falls, Smoking, and Aggressive Behavior.
( )	( )	6.	Emergency Procedures Address Possible Lost or Missing Participants.
( )	( )	7.	The Specialized Service is Staffed to Meet the Needs of Participants.
( )	( )	8.	The Staff Annually Receives Training in Specialized Care for the Population.
( )	( )	9.	Physical Environment and Design Features Address the Needs of the Special Care Population.
( )	( )	a.	Locking Devices (If Used In Program) Meet Requirements in N.C. State Building Code for Locking Devices.
( )	( )	b.	If Program Does Not Have Locked Doors, a System of Security Monitoring is Provided.
( )	( )	10.	Activities Offer Options Depending on Personal Preferences and Abilities of Participants.
( )	( )	11.	The Program Offers Involvement for Family/Caregivers.
( )	( )	12.	The Program Keeps and Disseminates Current Information on Family Support Groups and Other Resources for the Special Population.
( )	( )	13.	Enrollment Policies Disclose Additional Costs of Special Care Services and Ancillary Services Available, if Applicable.
			Care Includes:
( )	( )	1.	Participants Receiving Special Care Have Access to an Outside Area.
( )	( )	2.	The Outside Area is Secured or Supervised if Participants Have Impairments That Would Compromise Safety.

YES	NO		
( )	( )	3.	Disclosure Information Provided at Enrollment.
( )	( )	4.	Participant Meets Criteria for Special Population: Health Professional Documentation.
( )	( )	5.	If DD Participant, Has Been Through Single Portal. If N/A Check ( )
( )	( )	6.	Service Plans Based on Participants' Needs, Interests and Abilities.
( )	( )	7.	Service Plans Demonstrate a Balance of Activities, Optimum Functioning and Activities of Daily Living.
( )	( )	8.	If Participant is Transferred From Standard Adult Day Care to Special Care, Family or Responsible Person Agrees to Transfer.
( )	( )	9.	Service Plans Involve Environmental, Social and Health Care Strategies to Help Participants Attain or Maintain Their Maximum Level of Ability.
			Staff Orientation And Training
( )	( )	1.	Program Director Has Had Prior Specialized Training.
( )	( )	2.	Written Plan for Training Staff Identifies Content, Sources, Schedules of Training: Annual Update.
( )	( )	3.	Within 1 Month of Employment, Each Staff Person Assigned to Special Care Service Demonstrates Knowledge of Needs, Levels of Ability and Interests of Participants.
( )	( )	4.	Within 6 Months of Employment, Each Staff Person has Completed 3 Training Experiences.
( )	( )	5.	Each Direct Care Staff Completes 2 Population Specific Trainings Annually.
( )	( )	6.	All Training Experiences Documented in Center's Files.
			If Center Has A Special Care Services Unit:
( )	( )	1.	Unit is Separated By Closed Doors and Not a Pass Through Area.
( )	( )	2.	Unit Has Furnishings and Equipment Required for Number of Unit Participants.
( )	( )	3.	Unit Has at Least One Toilet.
( )	( )	4.	Unit Has Space Per Participant Required in Standards.
( )	( )	5.	Unit Has Participant/Staff Ratio Required in Standards.
( )	( )	6.	Participants Receiving Special Care Have Access to an Outside Area.
( )	( )	7.	The Outside Area is Secured or Supervised if Participants Have Impairments That Would Compromise Safety.

If NO is Checked for Any Standards Under SPECIAL CARE SERVICES PART 2, Please Explain and Comment Regarding Actions Needed and Program Plans to Insure Compliance:

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SUMMARY AND CONCLUSION (Use This Space for Evaluation of the Adult Day Health Program's Overall Service Delivery; Services and Activities Considered to be Exemplary; Any Information You Believe to Be Significant Which Is Not Included Elsewhere in This Report.

The County Department of Social Services Recommends:

( ) APPROVAL OF CERTIFICATION ( ) PROVISIONAL CERTIFICATION

( ) DENIAL OF CERTIFICATION ( ) REVOCATION OF EXISTING CERTIFICATION

If Provisional, Denial, or Revocation is Recommended, Please use a Separate Sheet of Paper for Statement of Reasons for Recommendation, Including Standards Which Have Been Violated and Factual Account of Actions Taken in Attempts to Correct Violations.

County Adult Day Health Coordinator

County Director of Social Services

Day Health Program Director or Operator

County Department of Social Services

LOCAL DEPARTMENT OF HEALTH

STANDARDS REVIEW
(PART B)

Name of Program: _____ County: _____

Name of Health Care Coordinator _____

Date of Report: _____

II. PERSONNEL
E. Health Care Coordinator

YES	NO			
( )	( )	1.		Health Care Coordinator on Site a Minimum of 4 Hours Per Day and Additional Hours as Specified in Standards.
		2.		Health Care Coordinator Responsibilities, Consistent with the Nursing Practice Act, Include But Are Not Limited To:
( )	( )		a.	Completing Preadmission Health Assessment for Initial Acceptance Into Program, Including Problem-Identification and Care Planning;
( )	( )		b.	Implementing the Health Care Components of the Established Service Plan;
( )	( )		c.	Monitoring Participant's Response to Medical Treatment Plan and Nursing Interventions and Revising Plan of Care as Necessary;
( )	( )		d.	Reporting and Recording Results of the Nursing Assessment, Care Rendered and Participant's Response to Care;
( )	( )		e.	Collaborating With Other Health Care Professionals and Caregivers Regarding Provision of Participant's Health Care;
( )	( )		f.	Educating Other Staff Members to Emergency Procedures and Providing Information to Staff and Caregivers About Health Concerns and Conditions of Participants;
( )	( )		g.	Providing First Aid Treatment as Needed.
		3.		Health Care Coordinator Meets the Following Minimum Qualifications:
( )	( )		a.	Either a Registered Nurse or a Licensed Practical Nurse Currently Licensed to Practice in North Carolina.
			b.	If the Health Care Coordinator is a Licensed Practical Nurse: If N/A, check ( )
( )	( )			(1) Supervision Is Provided by a Registered Nurse Consistent With The Nursing Practice Act and 21 NCAC 36 .0224 - .0225; and
( )	( )			(2) On-Site Supervision By The Registered Nurse Occurs No Less Frequently Than Every Two Weeks;
( )	( )		c.	Knowledgeable and Understanding of The Physical and Emotional Aspects of Aging, the Resultant Diseases and Infirmities and Related Medications and Rehabilitative Measures;
( )	( )		d.	At Least 18 Years of Age;
( )	( )		e.	Medical Report Presented Prior to Employment;

Distribution: Original to Adult Day Care/Day Health Consultant, one copy to Division of Aging and Adult Services, one copy to county department of social services, one copy to day health services program, and one copy for local health department.

YES NO

( ) ( ) f. At Least 3 Current Reference Letters or The Names of Individuals With Whom a Reference Interview Can Be Conducted.

F. Staff Responsible for Personal Care in Adult Day Health Centers

All Day Health Center Staff Providing Personal Care Present Evidence of Meeting the Following Qualifications Before Assuming Such Responsibilities:

( ) ( ) 1. Successful Completion of Nurse's Aide, Home Health Aide or Equivalent Training Course, Or

( ) ( ) 2. A Minimum of 1 Year of Related Experience.

G. Personnel In Adult Day Health Homes If N/A, Check ( )

( ) ( ) 1. Minimum of One Full-Time Equivalent Staff Person Designated as Having Responsibility for Direct Participant Care for Two to Five Participants. The Staff Person with this Responsibility May be the Operator or Other Designated Paid Staff.

( ) ( ) 2. Operator or Other Designated Paid Staff Meet the Requirements for Health Care Coordinator as Required in II.E., of the Standards and:

( ) ( ) a. Is Competent and Qualified to Carry Out the Responsibilities of Providing a Day Health Program;

( ) ( ) b. Has at Least Two Years of Related Work Experience and Ability to Manage All Aspects of a Day Health Program;

( ) ( ) 3. Substitutes or Relief Staff Used to Enable the Day Health Home to Remain Open on Days When the Operator is Not Available to Supervise the Program. Substitute or Relief Staff Meet the Requirements for Health Care Coordinator as Required in Standards.

If NO is Checked for Any Standard Under PERSONNEL, Please Explain and Comment as to Actions Needed and Program Plans to Insure compliance

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III. FACILITY

B. Treatment Room

( ) ( ) 3. Facility Includes a Treatment Room Which is Enclosed and Private From the Rest of the Facility. The Treatment Room Has a Sink or a Doorway Which Connects it to a Room Containing a Sink. The Treatment Room Contains a Treatment Table, Storage Cabinet for First Aid and Medical Supplies and Equipment, Table or Desk and Two Chairs. The Storage Cabinet is Kept Locked.

( ) ( ) 5. At a Minimum, the Following Medical Supplies and Equipment Are In The Treatment Room:

( ) ( ) a. First Aid Supplies
( ) ( ) b. Fever Thermometer
( ) ( ) c. Blood Pressure Cuff
( ) ( ) d. Stethoscope
( ) ( ) e. Medical Scales
( ) ( ) f. Privacy Screen
( ) ( ) g. Emesis Basin
( ) ( ) h. Bed Pan
( ) ( ) i. Urinal
( ) ( ) j. Wash Basin

If NO is Checked for Any Standard Under FACILITY, Please Explain and Comment as to Actions Needed and Program Plans to Insure Compliance:

YES	NO		
		IV.	**PROGRAM OPERATION**
		B.	**Health and Personal Care Services**
		1.	The Following Health Care and Personal Care Services Are Provided in Day Health or Combination Programs:
( )	( )		a. Assistance With Activities of Daily Living Including, But Not Limited to Feeding, Ambulation, or Toileting As Needed By Individual Participants;
( )	( )		b. Health Care Monitoring as Specified in Standards;
( )	( )		c. Assistance To Participants and Caretakers With Medical Treatment Plans, Diets, and Referrals As Needed;
( )	( )		d. Health Education Programs On A Regular Basis, At Least Monthly;
( )	( )		e. Health Care Counseling Tailored to Meet the Needs of Participants and Caretakers;
( )	( )		f. First Aid Treatment as Needed.
( )	( )	2.	Specialized Services Facilitated by Program as Required By a Physician and As Available Through Community Resources.
		F.	**Medications**
( )	( )	1.	Medications Administered According to the Participant's Established Medication Schedule or, For Non-Prescription Medications as Authorized by the Responsible Caretaker.
( )	( )	2.	Participants Are Allowed To Keep and Administer Their Own Medications. N/A ( )
( )	( )	3.	Medications Kept by Program Are Given to Participant to Take at Prescribed Times and Dosage. Documentation of Whether or Not The Medications Are Kept by the Program is on File.
( )	( )	4.	A Record of All Medications Given to Each Participant is Kept Including Each Dose and Other Required Information.
( )	( )	5.	Medications Kept by Programs Are in Containers In Which They Were Dispensed. The Medications are Clearly Labeled with the Required Information. Medications Kept By The Program Are Kept Locked In A Safe Place.

If NO is Checked for Any Standards Under PROGRAM OPERATION, Please Explain and Comment Regarding Action's Needed and Program Plans to Insure Compliance:

SUMMARY AND CONCLUSION (Use this Space for Your Evaluation of the Day Health Program's Overall Health Service, and Health Related Services and Activities Which Are Considered to be Significant And are Not Included Elsewhere in this Report.)

The Local Health Department Recommends:

( ) Approval of Program's Health Services

( ) Disapproval of Program's Health Services

If Program's Health Services are Not Approved, Please Use A Separate Sheet of Paper for Statement of Reasons for this Recommendation, Including Standards Which have been Violated and Factual Account of Actions Taken By the Program to Correct Violations.

Adult Day Health Specialist Date

Health Director Date

Health Specialist Phone Number

Health Department